Cervical Cancer Screening and Treatment Form

Ministry of Health

Client Number: _____ Visit Date (dd/mm/yyyy) _____ / _____ / _____

Client Name: _____ DOB (dd/mm/yyyy) _____ / _____ / _____ Phone No: _____

Treatment Supporter's Name: _____ Relationship: _____ Phone No: _____

Facility Name: _____ County: _____ Sub County: _____

Service Point: ☐ MCH/FP ☐ CCC ☐ GOPC ☐ Outreach Other (Specify) _____

Referred in: ☐ Yes ☐ No **If yes**, from _____ Reason for Referral: _____

Profiling: Is the client Pregnant ☐ Yes ☐ No If Yes, Gestational Age: _____

Visit Type: *(pick only one visit type and mark with a tick in the appropriate box)*

☐ Initial Screening ☐ Routine Screening ☐ Treatment Visit ☐ Post-Treatment Screening ☐ Post-Treatment Complications

Screening Method and Results:

VIA Test: ☐ VIA Negative ☐ VIA Positive **VILI Test:** ☐ VILI Negative ☐ VILI Positive ☐ Suspicious for Cancer

Pap Smear: ☐ Normal ☐ ASCUS/ASC-H ☐ LSIL ☐ HSIL/CIS ☐ AGUS ☐ Invasive Cancer

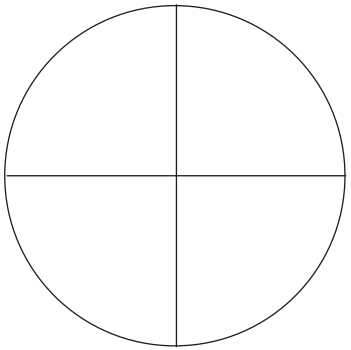
☐ Other *(Specify)*: _____

HPV Test: ☐ Negative ☐ Positive

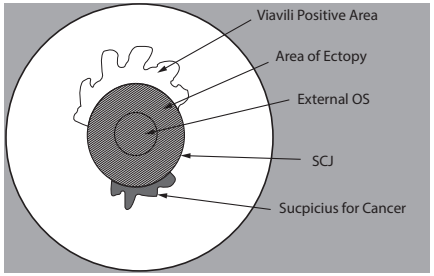
Intermediary Tests:

Colposcopy:	☐ Satisfactory	☐ Unsatisfactory	☐ Normal	☐ Acetowhite
	☐ Leukoplakia	☐ Punctuation	☐ Abnormal Vessels	☐ Mosaicism
Cervicography:	☐ Satisfactory	☐ Unsatisfactory	☐ Normal	☐ Acetowhite
	☐ Leukoplakia	☐ Punctuation	☐ Abnormal Vessels	☐ Mosaicism

Cervical Map: *(for VIA/ VILI/ Colposcopy)*



Illustration/Key



Pre-Cancer Treatment: Screening today, Cryotherapy performed today (Single Visit Approach - SVA) ☐ Postponed Cryotherapy done today

Other pre-cervical cancer specific treatment performed today (e.g. LEEP): _____ ☐ Other pre-cervical cancer specific treatment postponed (e.g. LEEP) _____

Screening today, Cryotherapy postponed; *Reason* _____

HIV Status: Negative Positive Known Positive Unknown	Post-Treatment complications related to: Cryotherapy LEEP Other *(specify):*
Follow up Date / Next Appointment: _____/_____/_____	Other Cervical cancer-related treatment (*Advanced Care Sites only*), Specify
Treatment for other ailments (specify):	

Referral Out *(If Applicable, fill the **Cervical Cancer Referral Form**)* referred to: _____

Provider's Name: _____ Cadre: _____ Signature: _____

ASCUS – Atypical Squamous Cells of Undetermined Significance
LSIL – Low grade Squamous Intraepithelial Lesion
ASC-H – Atypical Squamous Cells-High grade lesion not excluded
HSIL – High grade Squamous Intraeputhelial Lesion
AGUS – Atypical Glandular cells of Undetermined Significance
LEEP – Loop Electrosurgical Excision Procedure

Note: If HIV test not done in the last 1 year, then the status should be marked as Unknown